For about three years he has used with very satisfactory results a method of internal and external treatment which he calls the "intensive method," and which consists in saturating the system with creasote without inconveniencing the patient. For the internal treatment he prefers guaiacol dissolved in wine, or, in winter time, in cod-liver oil. The wine is given in tablespoonful doses, each of which contains about one grain of guaiacol. Little by little this is increased to 2–3 tablespoonfuls, until many patients are able to take 15 grains of guaiacol daily. In cases in which there is a disgust for the wine or it disagrees with the stomach, the author administers the drug by enema, in the form of an emulsion. The two forms of administration can sometimes be alternated with advantage, giving the drug by the mouth for twenty-five days, and then by the rectum for an equal time.

At the same time the author employs externally a mixture of 20 parts of creasote and 200 parts of cod-liver oil. On retiring, the patient's chest, back, and axillæ are rubbed with this. During the night, and when possible during the day also, an inhaler is worn, in which a few drops of creasote are placed.

Gradually the patient is, in this way, saturated with creasote in an amount sufficient to interfere considerably with the evolution of the bacilli. To obtain success the treatment must be continued without intermission for three to four months.

AN UNUSUAL ANOMALY OF THE PULMONARY VALVE.

STINTZING (*Deutsch. Arch. f. kl. Med.*, B. xliv. 149) describes, with an illustration, an interesting case of pulmonary insufficiency, the valve possessing only two leaflets. The patient was a woman of sixty-four years, who had always worked hard, had suffered several severe attacks of illness, and had borne six children. She had inflammation of the lungs eight months before, since which time she had experienced shortness of breath, cough, and pain in the side, head, and feet. More recently she had suffered from frequent attacks of palpitation and dizziness. When examined she exhibited cyanosis, constant cough, and a few rhonchi in the lungs. The apex-beat of the heart was diffuse; the cardiac dulness reached considerably beyond the right border of the sternum. There was diastolic murmur, whose point of maximum intensity was at the third and fourth cartilages on the left side. At the corresponding point at the right border of the sternum the murmur was fainter, and a dull but clear second sound could be heard.

The patient's condition grew worse, the apex-beat became weaker, albumin appeared in the urine. A very sharp post-systolic murmur could be heard at the left border of the sternum. At the origin of the aorta both sounds were dull but clear.

The autopsy revealed hypertrophy and dilatation of the right ventricle, some degree of emphysema of both lungs, and a defective formation with insufficiency of the pulmonary valve. Two of the leaflets, namely, were of normal appearance, while between them was an apparently rudimentary leaflet, leaving a triangular opening. The leaflet, which the author describes in detail, was smooth and covered by endothelium.

The author discusses the few reported cases, which in any respect have resembled his, and then endeavors to determine the mode of origin of this anomaly. He concludes that it is extremely improbable that the defect was due to endocarditis, which could hardly have been limited to *one* leaflet and have left it perfectly smooth and thin. It is also quite certain that the cause was not atheroma. The condition must have been congenital, though against this supposition is the fact that the patient had lived so long without cardiac symptoms, and with a disease which usually so soon makes its presence known. He believes this may be explained on the supposition that the insufficiency only became a matter of importance in later years with the widening of the lumen of the vessel. The emphysema or the inflammation of the lungs could have been the cause of the increased pressure which produced the widening of the pulmonary artery.

From a clinical point of view the case is also instructive, as showing the difficulty of distinguishing between this condition and insufficiency of the aortic valve. During life the case had been diagnosticated as the latter affection, and the author reviews the reasons justifying this diagnosis.

He concludes that pulmonary insufficiency can only be recognized, 1st, when the hypertrophy or dilatation of the right ventricle can by physical examination be distinguished from a like condition of the left ventricle (the diagnosis of this condition resting on the enlargement of the cardiac outline, especially toward the right with the apex beat felt more distinctly in this direction, and the presence of strong epigastric pulsation); 2d, when the pulse, in a state of good compensation, does not exhibit the characteristic quality of that of aortic insufficiency.

THE CAUSE OF ANÆMIC HEART-MURMURS.

At the close of a long discussion of this subject SEHRWALD (*Deutsch. med. Wochenschr.*, No. 21, 1889) draws conclusions, which may be summed up as follows:

1. In defining anæmic heart-murmurs the principal feature is that the heart is completely intact. All those attempts at explanation are therefore to be abandoned which resort to any secondary anatomical cardiac alteration.

2. So also, theories are untenable which explain some of the peculiarities of these murmurs, but leave others unexplained.

3. As none of the numerous hypotheses fulfil both of these conditions, a new one must be sought which rests solely on the existence of anæmia, and at the same time accords with clinical observations.

4. Of the many murmurs arising in the circulatory apparatus, only the venous hum can be considered analogous to the anæmic heart-murmur, since only this is due in like manner, and exclusively, to an under-filling of part or the whole of the vascular system with blood.

5. Venous murmurs are produced as soon as the lumen of the jugular vein becomes so narrow, on account of the imperfect distention, that the bulbus acts only as a sudden dilatation in which consequently the fluid makes eddies and noises. The anæmic heart-murmurs arise through an imperfect filling, and consequent narrowing, of the great veins emptying into the heart. The small quantity of blood contained in them pouring into the wide-open auricle, produces here also eddies and noises.